Texas Department of Insurance, Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1609

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

PART I: GENERAL INFORMATION

Requestor's Name and Address: MARY SHIELS HOSPITAL 3515 HOWELL STREET DALLAS TX 75204	MFDR Tracking #: M4-09-4649-01 DWC Claim #: Injured Employee:
Respondent Name and Box #: WILMER HUTCHINS I S D Rep Box #: 42	Date of Injury: Employer Name: Insurance Carrier #:

PART II: REQUESTOR'S POSITION SUMMARY AND PRINCIPLE DOCUMENTATION

Requestor's Position Summary taken from Appeal letter dated 11/18/2008: "The claim listed above was not processed according to Texas fee guidelines for outpatient services…TDI *§134.403* (4) for inpatient and outpatient services, state in subsection (b)(5)(d). For coding billing and reimbursement of health covered in this section, Texas workers' compensation participants shall apply Medicare payment policies in effect on the date a service is provided…CPT 63650 = $4,010.65 x 200% = $8,021.30; CPT 63650 = $4,010.65 x 200% = $8,021.30; CPT 76000 = $33.81 x 200% = $67.62; and CPT 76000 = $33.81 x 200% = $67.62. We are requesting (200%) of APC with a Medicare allowable of ($16,177.84) minus the payment received of ($13,933.76); we are rightfully owed ($2244.08)."

Principle Documentation:

1. DWC 60 package
2. Hospital Bill(s)
3. EOB(s)
4. Total Amount Sought $2,244.08

PART III: RESPONDENT'S POSITION SUMMARY AND PRINCIPLE DOCUMENTATION

Respondent's Position Summary: "With regard to the first CPT Code 64650, the Requestor billed $7,400. Respondent paid 100% of this amount. The fact that the MAR for this procedure is $8,021.50 is irrelevant. MAR is the *maximum* allowable reimbursement. If a provide chooses to bill less than the MAR, then that is well within their province. However, carriers are not expected to pay the MAR when services are billed under the MAR…With regard to the second CPT Code, 64650, the Requestor billed $2,200. Respondent paid 100% of this amount. Once again, the fact that the MAR for this procedure is $8,021.30 is irrelevant. MAR is the *maximum* allowable reimbursement. Providers may bill less than the MAR."

Principle Documentation:

1. DWC 60 response

PART IV: SUMMARY OF FINDINGS

Date of Service	Services in Dispute Per Table of Disputed Services	MAR Calculation	Amount in Dispute	Amount Due
07/16/2008	CPT code 63650 X 2	Not Applicable	$2,244.08	$0.00
			Total Due:	$0.00

PART V: REVIEW OF SUMMARY, METHODOLOGY AND EXPLANATION

Texas Labor Code Section 413.011(a-d), titled *Reimbursement Policies and Guidelines*, and Division Rule §134.403, titled ***Hospital Facility Fee Guideline – Outpatient,*** effective for medical services provided in an outpatient acute care hospital facility on or after March 1, 2008, set out the reimbursement guidelines for Hospital outpatient services.

This dispute was filed in the form and manner as prescribed by 28 TAC §133.307 and meets the requirements for medical dispute resolution under 28 TAC §133.305 (a)(4).

1. The disputed services were denied or reduced by the insurance carrier based upon:
   Explanation of benefits dated 07/18/2008 noted claim reduction codes:
   - 881 — This item is an integral part of an emergency room visit or surgical procedure and is therefore included in the reimbursement for the facility/APC rate.
   - 97 — Payment is included in the allowance for another service/procedure.

   Explanation of benefits dated 08/15/2008 noted claim reduction codes:
   - 787 — No reason code description listed on EOB.

   Explanation of benefits dated 12/04/2008 noted claim reduction codes:
   - ** — This procedure on this date was previously reviewed.
   - 18 — Duplicate claim/service.
   - ** — Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.
   - W1 — Workers Compensation State Fee Schedule Adjustment.
   - W4 — No additional reimbursement allowed after review of appeal/reconsideration.
2. The Respondent denied reimbursement based upon duplicate claim/service. The disputed service was a duplicate bill submitted for reconsideration of payment. The respondent did not provide information/documentation of duplicate payments. Therefore, this payment denial reason has not been supported.
3. Rule 134.403 (e) states in pertinent part, "Regardless of billed amount, reimbursement shall be:
   (1) the amount for the service that is included in a specific fee schedule set in a contract that complies with the requirements of Labor Code 413.011; or
   (2) if no contracted fee schedule exists that complies with Labor Code 413.011, the maximum allowable reimbursement (MAR) amount under subsection (f), including any applicable outlier payment amounts and reimbursement for implantables."
4. Pursuant to Rule 134.403(f), "The reimbursement calculation used for establishing the MAR shall be the Medicare facility specific amount, including outlier payment amounts, determined by applying the most recently adopted and effective Medicare Outpatient Prospective Payment System (OPPS) reimbursement formula and factors as published annually in the *Federal Register*. The following minimal modifications shall be applied.
   (1) The sum of the Medicare facility specific reimbursement amount and any applicable outlier payment amount shall be multiplied by:
      (A) 200 percent; unless
      (B) a facility or surgical implant provider requests separate reimbursement in accordance with subsection (g) of this section, in which case the facility specific reimbursement amount and any applicable outlier payment amount shall be multiplied by 130 percent."
5. Upon review of the documentation submitted by the requestor and respondent, the Division finds that:
   (1) No documentation was found to support a contractual agreement between the parties to this dispute;
   (2) MAR can be established for these services; and
   (3) Separate reimbursement for implantables *was not* requested by the requestor with the billing.

6. Under the Medicare Outpatient Prospective Payment System (OPPS), all services paid under OPPS are classified into groups called Ambulatory Payment Classifications or APCs. Services in each APC are similar clinically and in terms of the resources they require. A payment rate is established for each APC. Depending on the services provided, hospitals may be paid for more than one APC for an encounter. Within each APC, payment for ancillary and supportive items and services is packaged into payment for the primary independent service. Separate payments are not made for a packaged service, which is considered an integral part of another service that is paid under OPPS. An OPPS payment status indicator is assigned to every HCPCS code. Status codes are proposed and finalized by Medicare periodically. The status indicator for each HCPCS codes is shown in OPPS Addendum B which is publicly available through the Centers for Medicare and Medicaid services. A full list of status indicators and their definitions is published in Addendum D1 of the OPPS proposed and final rules each year which is also publicly available through the Centers for Medicare and Medicaid services.
7. The requestor lists CPT codes 63650 x 2 as the codes in dispute.
8. Pursuant to Division rule at 28 TAC §133.307(c)(2)(E), "Provider Request. The provider shall complete the required sections of the request in the form and manner prescribed by the Division. The provider shall file the request with the MDR Section by any mail service or personal delivery. The request shall include: (E) a copy of all applicable medical records specific to the dates of service in dispute."
9. Thorough review of the documentation submitted by the requestor finds that the requestor did not submit any medical records to identify or support the disputed services in accordance with Division rule at 28 TAC §133.307(c)(2)(E). Because the Division has not been provided sufficient documentation to determine services in dispute, reimbursement is not recommended.

Based upon the documentation submitted by the parties and in accordance with Texas Labor Code Sec. 413.031 (c), the Division concludes that the requestor is not due additional payment. As a result, the amount ordered is $0.00.

PART VI: GENERAL PAYMENT POLICIES/REFERENCES

Texas Labor Code Sec. §413.011(a-d), §413.031 and §413.0311
28 TAC Rule §134.403
28 TAC Rule §133.307
28 TAC Rule §133.305

PART VII: ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the services involved in this dispute.

		June 1, 2010
Authorized Signature	Medical Fee Dispute Resolution Officer	Date

PART VIII: YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **20** (twenty) days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. **Please include a copy of the Medical Fee Dispute Resolution Findings and Decision** together with other required information specified in Division Rule 148.3(c).

Under Texas Labor Code Section 413.0311, your appeal will be handled by a Division hearing under Title 28 Texas Administrative Code Chapter 142 Rules if the total amount sought does not exceed $2,000. If the total amount sought exceeds $2,000, a hearing will be conducted by the State Office of Administrative Hearings under Texas Labor Code Section 413.031.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.